Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING
April 6, 2006
Elihu M. Harris State Building
Oakland, California

In Attendance

Chair Angie Wei
Commissioners Allen Davenport, Kristen Schwenkmeyer, Alfonso Salazar, Robert B. Steinberg, Darrel "Shorty" Thacker and John Wilson
Executive Officer Christine Baker

Not in Attendance

Commissioner Leonard C. McLeod

Call to Order

Chair Angie Wei, 2006 Chair of the Commission, called the meeting to order at 1:07 p.m.

Minutes from the February 9, 2006 Meeting

CHSWC Vote

Commissioner Wilson moved to approve the Minutes of the February 9, 2006 meeting, and Commissioner Thacker seconded. The motion passed unanimously.

A Proposal on Quality of Medical Care in Workers' Compensation: A California Demonstration Project

Teryl Nuckols Scott, MD, MSHS, David Geffen School of Medicine at UCLA

Dr. Teryl Nuckols Scott stated that a recent landmark study by RAND found that across all healthcare settings, adults in the U.S. receive only about half of the care as recommended by published literature and experts. Researchers on the project also found that quality-of-care problems are pervasive for back and joint injuries, for which a third to half of U.S. patients do not receive the right care. Dr. Nuckols Scott stated that this was the largest and most comprehensive study in the United States to date on problems with the quality of medical care provided in this country. She also stated that there have not been any studies examining the quality of the medical care provided to injured workers, in California or elsewhere. The generally poor quality care provided for back and joint injuries suggests that many injured workers probably do not receive the right care either. The demonstration project would attempt to suggest a mechanism for monitoring and improving the quality of care provided to injured workers.

Dr. Nuckols Scott stated that she would provide background on why quality of care is a particularly important issue in workers' compensation; outline the goals and objectives of the proposed demonstration project, describe the research approach, and discuss some partnerships that could help to make the study possible. She stated that there are several reasons to believe that ensuring that workers receive high-quality medical care would benefit both workers and employers. From the workers' perspective, better medical care would enable workers to make faster and more complete recoveries, because time off work drives economic losses for injured workers, and reducing temporary and permanent disability would benefit them financially as well. From the employers' perspective, a lack of a recovery can create a need for more medical care over time, increasing medical costs; and reducing temporary and permanent disability would decrease those economic losses for employees.

Dr. Nuckols Scott also stated that some published research supports the idea that improving quality of care can benefit both workers and employers. In a recent study, researchers randomized over 13,000 workers with musculoskeletal problems to either usual care or a quality-improvement program. In the quality-improvement program, specialists in musculoskeletal injuries managed patients in accordance with defined treatment protocols and provided intensive patient counseling and education about appropriate activity levels and return to work. This program succeeded reducing time on temporary disability by 37%; showed that the percentage of temporarily disabled workers going on the permanent disability dropped by 50% and total medical and disability costs fell 37%. In fact, each dollar invested in the program generated a savings of $11.00. This study was done in Spain, so the exact quality-improvement program might or might not have similar success here in the U. S. However, Dr. Nuckols Scott commented, a smaller study in Washington State succeeded in reducing disability costs by 30% by improving adherence to treatment protocols and encouraging providers to prescribe activity and plan for return to work. The results of these two studies strongly support the idea that better quality medical care can reduce both disability and its associated costs

Dr. Nuckols Scott commented that the goal for the proposed project would be to demonstrate quality measurement in a workers' compensation setting. The quality of the care provided in the California workers' compensation system is a complex issue affecting a wide range of stakeholders. A demonstration project would approach this complex problem in an incremental, iterative fashion. It would provide an opportunity to try something out on a relatively smaller scale, to involve stakeholders in the process, and to learn about potential issues that may arise if a policy or program were to be implemented on a larger scale. The demonstration project would involve four principal objectives: to develop quality-of-care indicators for one work-related disorder; to apply quality-of-care indicators to patients from several medical networks; to publish an anonymous report card comparing quality across the networks; and to consider how to translate the project into an ongoing quality-monitoring system.

Dr. Nuckols Scott discussed what an anonymous report card might look like, indicating the degree to which quality care was provided and the degree to which it was not provided. Comparing the networks would indicate which provides the poorest quality care and which provides the best. She next stated that the target condition chosen is carpal tunnel syndrome and that steps in the project are closely aligned with the four research objectives.

Dr. Nuckols Scott stated that quality-of-care indicators are explicit, measurable standards for care. Such indicators facilitate objective, accurate evaluations of current practice. They also ensure that results can be compared fairly among organizations or providers. To function for these purposes, the indicators should have several specific attributes: they must be relevant, scientifically sound, and feasible for measurement; and to be feasible for measurement, they must be defined in detail, including qualifying terms, time frames, patient eligibility, and other factors. She pointed out that although quality-of-care indicators are related to medical treatment guidelines, there is an important difference, guidelines are not designed to be used for measurement and, therefore, will not produce data about quality of care that is objective and scientifically sound. In summary, indicators are more explicit and specific than guidelines.

Dr. Nuckols Scott stated that the study has identified several existing indicators relevant to workers' compensation and that these indicators appear to need refining or updating. Dr. Nuckols Scott stated that given that existing indicators do not appear to be usable without a great deal of additional work, the study proposes to develop indicators for carpal tunnel syndrome. Carpal tunnel syndrome was chosen as the demonstration project emphasis for three reasons: (1) prior RAND research determined that surgery for carpal tunnel is a cost-driver in the California workers' compensation system; (2) in addition, developing indicators for carpal tunnel syndrome will be less complicated than for other common and costly disorders, like back pain, because carpal tunnel is a well-circumscribed problem, and an objective test can confirm the diagnosis. During development work on the study, many stakeholders and experts agreed that carpal tunnel would be a suitable place to start. In the long-term, monitoring quality of care would obviously require indicators for additional work-related conditions. The proposed demonstration project would develop the indicators using highly valid methods developed by RAND. These include identifying important aspects of clinical care and developing preliminary indicators from the scientific literature and widely accepted guidelines. The ACOEM Guideline would be our preferred guideline, unless there was scientific reason to use a different source of preliminary indicators. Next, a panel of experts would be convened to refine the indicators. The experts would be asked to prioritize the indicators and to choose a "core" set representing the most important aspects of care for carpal tunnel. This would provide an option to limit the scope of project to the highest-priority issues down the road. The last step, a very labor-intensive one, would be defining the application of indicators in detail.

Dr. Nuckols Scott stated that the project development work provided an opportunity to interview a number of experts in carpal tunnel syndrome treatment, particularly in workers' compensation settings and to consider key guidelines and medical literature. On these bases, some preliminary aspects of care and outcomes on which the indicators might focus have been identified. The indicators that will actually be developed will probably differ from this framework to some degree, depending on what aspects of care are feasible for measurement, how strong the relevant literature is, and what the study panel believes is important. Once the indicators have been developed, the next proposed step would be to compare current practices in participating medical networks to the indicators. Dr. Nuckols Scott stated that the researchers suggest having the demonstration project focus on quality provided by the medical networks because they were established to facilitate economic profiling in contracting decisions. Since studies suggest that

quality of care has economic implications, as discussed earlier, quality profiling seems related to economic profiling. Dr. Nuckols Scott also stated that in the long-term, network contracting could be used to create incentives for improving quality of care. For this demonstration project, the methods of evaluating care in the networks would involve the following steps: confirming participation with interested networks; randomly sampling patients in each network; and having nurses compare care documented in medical records to the indicators.

Dr. Nuckols Scott stated that a key question would be whether medical networks are really going to allow measurement of the quality of the medical care they provide. She then stated that several medical networks have expressed strong interest in participating. Several of the networks have already been trying to determine how to ensure that the care they provide is high quality. Participating in the study provides them with an opportunity to do so. Some networks have even expressed a willingness to make results public.

Dr. Nuckols Scott stated that the next step in the project would be to create an anonymous report card that would compare the participating networks. A public report-card approach is a common strategy for improving quality of care. Networks would be offered the choice to remain anonymous because: publishing the names of the networks could penalize those most interested in leading the quality-improvement effort. In addition, purchasers in the long-term would obviously need objective, publicly available information about quality, and providing the participating networks with anonymity is one way to take an incremental, iterative approach designed to minimize the potential risks to the various stakeholders.

Dr. Nuckols Scott stated that the methods proposed to be used to develop the demonstration project report cards would be to: statistically compare adherence to quality-of-care indicators across the networks; determine stakeholders' preferences in report card format and content; and then publish the demonstration project report card on line. The final consideration would be whether and how the demonstration project might be translated into an ongoing system for monitoring quality of care. Dr. Nuckols Scott stated that through recent project development work, already several considerations have been developed, including: quality-of-care indicators would be needed for several work-related disorders; regulatory or legislative changes might facilitate quality-of-care profiling in addition to economic profiling by the medical networks; in an ongoing system, a neutral organization should be chosen to evaluate and report quality of care so that the findings have credibility among stakeholders; and lastly, ongoing quality-monitoring activities would require an ongoing source of funding. Dr. Nuckols Scott commented that although costs of monitoring could decline as electronic health records become more established, this still seems several years off.

Dr. Nuckols Scott stated that with the support of the Commission, some supporters of the project have been identified. Christine Baker has been instrumental in identifying relevant organizations, helping to make contact with them to discuss the project, and discussing the project with them. As a result of combined efforts, one insurance company and one medical network have indicated a willingness to provide funding support in the amount of $250,000 each. Four additional medical networks have indicated a willingness to partner in kind by supporting data collection within their networks. It is estimated that partnering in kind will benefit the

project as much as if each network contributed $100,000. Discussions with a couple of additional networks are in process.

Dr. Nuckols Scott stated that developing indicators and measuring quality of care via medical-record review, which would be required in the study, are labor-intensive activities that require highly skilled health care professionals. The potential budget of a very comprehensive project, with a larger set of quality indicators for carpal tunnel, assumes that six medical networks would be able to partner in kind. To make such a project possible, a number of additional sponsors would need to be identified to raise $1.4 million. Measuring quality of care using only the core indicators would bring the budget down quite a bit, but another $600,000 would still need to be raised. The last option would be to apply the core indicators to one medical network, which would still achieve the overarching goal of demonstrating quality measurement in a workers' compensation setting, would reduce the amount of additional funding needed to only an additional $250,000. However, creating a comparative report card would not be feasible if we include only one network. Dr. Nuckols Scott stated that the project team is hopeful that additional organizations would be willing to contribute to this important project, particularly because the project findings would also have implications for workers' compensation care in states other than California.

Dr. Nuckols Scott stated that conclusions include that high-quality medical care appears more important in workers' compensation settings than anywhere else in healthcare, because low-quality care can impede recovery and increase cost. The quality of the care injured workers receive should, therefore, be monitored over the long term. This would require quality indicators for a range of work-related conditions. Carpal tunnel syndrome seems to be a good place to start. Network contracting could create incentives for improving quality. Therefore, studying the care provided in several networks would be a good place to start. To support contracting decisions that consider quality of care, purchasers would need objective information. An anonymous report card would show purchasers what this information would look like and how it could be used.

Commissioner Davenport asked whether studies in this area are comprehensive. Dr. Nuckols Scott replied that the most comprehensive study to date in the U. S. has looked at a wide range of conditions and many aspects of care and patients from all around the country. The study from Spain is a very different study, because it had only a quality-improvement program which could generate substantial savings. Commissioner Wilson asked what the next steps for the study would be if the Commission decided to proceed. Christine Baker replied that the proposal would be to proceed with the study; the Commission's commitment would be to go through UCLA with an inter-agency agreement for $250,000, which would be approximately $125,000 this fiscal year and $125,000 next fiscal year. The Commission would be one of the partners in the project. This would be a public-private partnership. Commissioner Wilson asked what kind of timeline there would be if the Commission took action on the proposal today. Ms. Baker replied that the inter-agency agreement could be established fairly quickly but the timeline would depend on the funders. Dr. Nuckols Scott stated she believed that the best role for the Commission would be to support the development of the quality indicators. This would be an advance over what is available now. Chair Wei asked if a first step would be to publish the indicators before creating

the comparative report card. Dr. Nuckols Scott replied that it would. For a comparative evaluation, the additional funds would be needed.

Commissioner Steinberg asked for clarification of the funding. Ms. Baker stated that the sources of funding would be partially private, but commitments are not known specifically at this time. The Commission's part of the project, the development of quality indicators, would be independently developed. Any further expansion on the project would be funded directly through RAND, independently of the Commission. Commissioner Steinberg stated that it seemed that the Commission would be providing seed money. Ms. Baker replied that it would. Chair Wei asked if the indicators piece would be published under the Commission. Dr. Nuckols Scott stated that there would be both a surgical indicator and a non-surgical indicator. Commissioner Wilson asked what the prospects were for doing a comprehensive study. Dr. Nuckols Scott replied that it would be over-ambitious. Commissioner Wilson asked if any money has to be raised before the study starts. Dr. Nuckols Scott stated that the project can move forward at this time, and Ms. Baker asked if the quality-indicator development could be done without more definite commitments from other parties. Dr. Nuckols Scott stated that it could. Chair Wei asked if the investment from the Commission would result in a published study on indicators regardless of whether or not the two existing verbal commitments were realized. Dr. Nuckols Scott replied that it would result in a published study.

Public Comment

Kristine Schultz from the California Chiropractic Association asked how the non-surgical quality indicators would treat chiropractic and acupuncture. Dr. Nuckols Scott stated that these therapies are being done for carpal tunnel syndrome. She stated that there is not an overwhelming amount of evidence that these treatments should be done for carpal tunnel. She then stated that the study would emphasize the therapies that everyone with carpal tunnel syndrome should get. Ms. Schultz asked if there would be bias against patients treated in those settings. Dr. Nuckols Scott stated that it would be expected that these therapies would be included in basic medical care and there would be indicators applied to those patients receiving those therapies.

Chair Wei stated that she believes that this study is an important step for the Commission because it focuses on quality care.

CHSWC Vote

Commissioner Davenport moved to approve that CHSWC approve the Proposal on Quality of Medical Care in Workers' Compensation: A Demonstration Project, and Commissioner Wilson seconded. The motion passed unanimously.

Chair Wei stated that she is asking Commission staff to follow up with the Division of Workers' Compensation (DWC) on the status of repackaged drugs and to have the DWC provide an update on its work. She stated that this will remain an ongoing request.

A Report on Repackaged Drugs

Frank Neuhauser, Survey Research Center, UC Berkeley

Mr. Neuhauser stated that he would discuss the study by looking at the frequency and cost of physician-prescribed and physician-dispensed drugs in workers' compensation. This study has been funded by the Commission and assisted by Commission staff and the California Workers' Compensation Institute (CWCI), particularly Alex Swedlow and Barbara Wynn. Ed Edelstein, who was one of the original editors for a First Data Bank, which is one of the key comprehensive sets of pricing guides for pharmaceutical drugs, has been very generous in supplying information on how the pricing of drugs has changed and the way in which the data have been described in the First Data Bank. Mr. Neuhauser stated he would cover topics such as: pharmacy pricing, with examples of how the prices are constructed; physician-dispensing, how it happens and why it is priced differently from pharmacy-dispensing in workers' compensation; an explanation of the data used on this project and their estimates of the impact of physician-dispensed drugs on employers' costs; arguments for and against physician-dispensing that have been proposed by various stakeholders; and some conclusions.

Mr. Neuhauser stated that he would discuss what determines the actual price paid for pharmaceuticals in workers' compensation and in healthcare in general. Traditionally, the most important benchmark used to determine the maximum reasonable fees in workers' compensation has been the Average Wholesale Price (AWP). However, the AWP has become much less commonly used because it no longer represents the actual wholesale price paid by pharmacies. More commonly-used prices for drugs with generic equivalents are the widely available Maximum Allowable Ingredient Cost (MAIC) or the Federal Upper Limit ingredient costs. These tend to be much lower than AWP. A second component after the ingredient cost is the cost of pharmacist services or cost of the dispensing fee. Mr. Neuhauser also stated that one of the factors that control costs is generic substitution for more expensive brand-name drugs. A couple of other controls used in group health that have not been used in workers' compensation are formularies and contract prices. Formularies restrict the use of more expensive drugs and also allow the group-health provider or the federal government or the state (in the case of MediCal) to get rebates from drug companies. Also, group-health providers often contract for specific prices, as part of their group-health contract, with companies or pharmacies, acting as a controlling process. Mr. Neuhauser stated that the AWP is now probably the worst benchmark for pricing. It is unrelated to the actual ingredient cost, it is highly inflated, and over time, it has become increasingly inflated.

The top three drugs that are physician-dispensed in workers' compensation cases are: Carisoprodol (Soma), a muscle relaxant; Ranitidine (Zantac), an antacid; and Naproxen (Naprosyn), a non-steroidal anti-inflammatory. In the case of Zantac, the average of the AWP is 12-15 times higher than the pharmacy reimbursement in workers' compensation, which is based on the MediCal fee schedule. The same thing is true for Soma and for Naprosyn, although the differences between physician-dispensed pricing and Medical pricing are a little less.

Mr. Neuhauser stated that First Data Bank provides a key data source used for the study and is also used by group health, pharmacies and other sources. MediCal and the federal government Medicaid programs get their data from this source and they create their own lists of pricing. The First Data Bank sources are also used commercially.

Mr. Neuhauser stated that prior to the Commission's work in 1999 and 2000, the Official Medical Fee Schedule (OMFS) pricing for workers' compensation was 1.4 times the AWP plus $7.50 professional fee for the pharmacists for generic drugs and 1.1 times the AWP plus $4.00 dispensing fee for brand names. As a result of the Commission's work, done at the request of the Legislature, in Senate Bill (SB) 228 aligned workers' compensation with MediCal payments. MediCal currently pays 0.83 times AWP plus $7.25 as the professional fee when there is no other price or when the doctor says there is no substitution and the patient has to be given that particular drug. Mr. Neuhauser stated that most of the time the controlling price is the Federal Upper Limit or MAIC which are much lower than AWP.

Chair Wei asked Mr. Neuhauser to clarify what dispensing physicians currently receive and what retail pharmacies currently receive. Mr. Neuhauser stated that physicians can dispense under California law from their office. There is a code and some restrictions as to what they can do. The physicians have to purchase the drugs themselves, and then they can dispense them from their private office. They generally purchase repackaged drugs, which are drugs that have been bought up by drug suppliers in large amounts and repackaged into individual amounts (30, 60, 90, etc. tablet amounts) and supplied to the physician. The physicians sell those individually packaged amounts out of their office and can bill workers' compensation insurers under the old medical fee schedule. The repackaged drug codes are not listed on the MediCal formulary because MediCal does not allow for payment of repackaged drugs, so there is no identification number on the MediCal pricing. The interpretation of the law according to workers' compensation is that because the drugs being sold did not have a price on the MediCal schedule, they reverted to pricing under the old Official Medical Fee Schedule (OMFS) pricing scheme. The DWC has had the opportunity to issue new regulations, but so far, from the time when the new fee schedule was put in place, until March 6, 2006, there have been no regulations. Consequently, all repackaged drugs can be sold under the old OMFS.

Mr. Neuhauser stated that until this Commission study, there had been no information about the number of physicians dispensing drugs, how many of the drugs in workers' compensation were being dispensed by physicians from their offices, and the estimate of impact on employer cost. Commissioner Davenport asked Mr. Neuhauser how many physicians are dispensing drugs from their office. Mr. Neuhauser replied that it is difficult to determine how many physicians are actually dispensing repackaged drugs from their office because the database only shows how many different federal identification numbers are being reimbursed. In the database, 1900 federal identification numbers are getting individually reimbursed. Mr. Neuhauser stated that an important fraction of occupational physicians and a small fraction of all physicians in California are dispensing repackaged drugs. Another third of prescriptions that are physician-dispensed are handled by an intermediary in workers' compensation, which might represent an additional 50% of physicians prescribing and dispensing. Therefore, Mr. Neuhauser stated, approximately 3,000-5,000 physicians are involved dispensing pharmaceuticals from their regional offices.

Commissioner Davenport asked if there is a regional bias, either urban or rural. Mr. Neuhauser stated that they do not know that since the database only gives the federal identification numbers. There are no addresses in their database; however, it could be possible to determine if an address is attached to payments. The CWCI would probably be best able to answer the question if the information is in their database.

Mr. Neuhauser stated that the data came from the ICIS database of the CWCI, which has been used by a number of studies by the Commission and has been used by a number of other people analyzing workers' compensation issues in California. The ICIS database is a transactional database that has all of the transactions that occur on all of the workers' compensation cases for about 70% of insured work injuries. In this case, the sample is approximately 1.2 million prescriptions paid for service dates 2000-2004. The data include a drug code that identifies which drug was being paid, the number of units, the amount billed, the amount paid, and whether the drug was a repackaged drug. Mr. Neuhauser stated that the data give the drugs being dispensed and whether they are repackaged drugs. The pricing information is based on the drug code, AWP, Federal Upper Limit prices, the identifier for repackaged drugs, and generic equivalence which groups similar drugs that have different NDC codes. Finally, MediCal pricing data were used to establish MediCal prices for a drug, including the "low-cost" price and a "no substitution price" based on using a particular drug when the doctor prescribes that no other drug can be used, and the discount to the AWP. Using these three databases, a model can be put together that estimates the percentage of drugs in workers' compensation that are being physician-dispensed, how much these drugs cost, and how much they cost relative to the drugs being prescribed and distributed through a pharmacy.

Mr. Neuhauser stated that most physician-dispensed drugs are repackaged generic drugs. In the case of Zantac, about 99.9% of the time, Ranitidine, the generic form of Zantac, is typically being dispensed. This is the same for the other five or six top drugs. The only drug, Mr. Neuhauser stated, that is not predominantly generic is Celebrex. The top 20 physician-dispensed drugs account for 93% of all the costs for those drugs dispensed. The AWP times 1.4 is almost always the controlling maximum price as under the old schedule. These same drugs, because they are predominantly generic drugs, are dispensed at the pharmacy under prices controlled by the Federal Upper Limit price.

Mr. Neuhauser pointed out the example of Naproxen (or Naprosyn), a non-steroidal anti-inflammatory that is better known as Aleve for those who buy drugs over the counter. For the 150 mg dose of Aleve, MediCal pays 18 cents per tablet. Mr. Neuhauser stated that the modal prices for the AWP times 1.4 for physician-dispensed drugs were as follows: about 50% of the drugs have an AWP times 1.4 that falls between $2.10 and $2.20, as compared to 18 cents for pharmacy; 30% of the drugs have an AWP that falls between $2.50 and $2.60, also compared to 18 cents; and 50% have an AWP that falls between $2.90 and $3.00 per tablet. There are smaller numbers that range anywhere from about $1.80 to $7.58 for the AWP, but these are the main groupings of prices. One can see the differences from the MediCal prices. Mr. Neuhauser stated that it is not that the AWPs for these drugs are so unusual, as the AWPs for the drugs the pharmacies dispense are also high, but that the AWPs are completely unrepresentative of what

pharmacies are actually paid. MediCal almost always pays for the drugs in the preceding examples under the Federal Upper Limit or MAIC price, which are typically a fraction of the AWP.

Chair Wei asked Mr. Neuhauser to clarify the payments to physicians and pharmacies. Mr. Neuhauser replied that the AWPs for the drugs that the pharmacies are dispensing are also much inflated, but they are also not as high as the physician ones, and the pharmacies are also not getting paid based on the AWPs; they are getting paid the 18 cents. Chair Wei asked Mr. Neuhauser to clarify if Naproxen is the same as Aleve, or is like Aleve. Mr. Neuhauser replied that Aleve is the generic brand of Naproxen and might even be made by the same company. A member of the audience stated that the two have different manufacturers and different strengths.

Mr. Neuhauser provided data on the top three drugs dispensed by workers' compensation, and some examples of pricing differences based on purchasing 60 tablets of the three most popular dispensed drugs are: Ranitidine (Zantac), Carisoprodol (Soma), and Naproxen (Naprosyn). MediCal's price of Zantac is $13.85, while the average repackage price is $201.60, with a difference of 1400% times what the pharmacy gets. MediCal's price of Soma is $29.45 for the same 60 units, while the physician average repackage price is $268.00, making a difference of 910%. Finally, Naprosyn's MediCal price is $18.05, while an average repackage price is $145.80, with a difference of 800%.

Mr. Neuhauser stated that when the study began, it was expected that only a few physicians were dispensing drugs, but as the study indicates that there are about 3,000-5,000 physicians dispensing repackaged drugs from their offices, physician-dispensing has become a serious concern. Mr. Neuhauser stated that 30% of prescriptions are repackaged drugs dispensed from physician offices, while 50% of the dollars that we spend on prescription costs are for physician-dispensed drugs paid under workers' compensation.

Mr. Neuhauser stated that the Workers' Compensation Insurance Rating Bureau (WCIRB) 2005 report indicated that insured employees paid $476 million in 2004 for pharmaceutical costs in workers' compensation. Mr. Neuhauser also stated that a pretty standard rate of growth in the non-worker's compensation world for drugs is about 12% per year. Newer, better, and more expensive drugs are constantly becoming available; therefore, workers' compensation pharmacy costs had been growing much faster prior to the application of the fee schedule. However, that fee schedule is going to shift the level of pricing down, so a growth rate similar to what we see across the country for group health pharmaceuticals can be expected. Assuming a national 12% growth rate, $600 million was the estimated paid amount in 2006 for insured employers, and $840 million was the amount paid system-wide, including self-insured employers and state agencies. About half of that amount, or $420 million of the paid amounts, are going for repackaged drugs. Mr. Neuhauser stated that the paid amounts are not what employers are paying, but what insurance companies pay. Employers are paying what the insurance companies estimate the incurred costs will be for the future. Therefore, incurred costs for 2006 are calculated at about twice what is on a paid basis.

Mr. Neuhauser stated that pharmacies distribute a different set of drugs than physicians who dispense repackaged drugs. Pharmacy prices would be about 45% higher in the absence of SB 228, with costs of about $120 million on a paid basis and about $240 million on an incurred basis, which account for what employers are saving under SB 228. On the other hand, physician-dispensed drugs on average across the whole group of drugs dispensed are about six times more expensive when dispensed from a physician's office than when supplied through a pharmacy. Mr. Neuhauser stated that in 2006, the cost impact of physician-dispensing can be measured at an estimated difference between $72 million if the pharmacy dispensed the drugs versus $420 million if physicians dispensed the drugs. The cost impact of physician-dispensing for the employers' cost incurred plus some allowance for administrative costs in 2006 was an estimated $144 million if the pharmacy dispensed the drugs versus $840 million if the physician dispensed the drugs over the life of claims, assuming no changes made in the law. Therefore, on a policy-year 2006 basis, this is a staggering increase in cost, about $700 million increase for the cost of policies, because physicians are dispensing the drugs rather than the drugs being dispensed through a pharmacy.

Mr. Neuhauser stated that arguments for physician-dispensing deal with issues of access, compliance, improved health outcomes, life-saving therapies, better patient information and safety, and language barriers. In regard to access, Mr. Neuhauser stated that proponents of physician dispensing claim it is easier for patients to get drugs from their physician's office and that some patients can not get drugs in many cases from pharmacies because the pharmacies in their area do not dispense the drugs. This is an issue that has been addressed prior to SB 228 reductions. The evidence in that study found no indication of an access problem for workers, with a very large fraction of workers within short distances of at least one pharmacy filling workers' compensation prescriptions. If anything, the data indicate that access is even better now than it was prior to SB 228.

The second issue is compliance, whether or not patients actually get the prescription filled and take the drugs as prescribed. That they get the prescription clearly is more likely, as there is insurance that the patient will get the drug when dispensed from their physician's office, as opposed to failing to fill the prescription. However, there is very little evidence that patients are more likely to follow the proper regime because they got the drug through the physician, and no evidence that physician-dispensing improves outcomes. Mr. Neuhauser also stated that there have also been some arguments that physician-dispensed drugs are life-saving and time-critical and therefore have to be dispensed under those circumstances. Again, Mr. Neuhauser stated, there is no evidence among the top 50 physician-dispensed drugs, accounting for 99% of all physician dispensed drugs, that any were time-critical or immediately life-saving. Mr. Neuhauser then stated that a final argument is that physician-dispensing will provide better patient information and safety, as well as a reduction in language barriers.

Mr. Neuhauser next stated that arguments against physician-dispensing involve cost, and it is important to consider whether the advantages of physician-dispensing are outweighed by the cost, and whether even if physician-dispensing is allowed to continue there should be some adjustment to the cost structure. Mr. Neuhauser then stated that there is also the issue of incentive to over-prescribe and the issue of whether over-prescribing changes physician

behavior. Still another argument is that there is an incentive to prescribe what is in stock, as opposed to using the wider range of drugs available, some of which may be therapeutically superior. Mr. Neuhauser then stated that in regard to the claim that physician-dispensing improves information provided to patients, opponents have stated that there are limits to patient information and reductions to patient safety checks.

Mr. Neuhauser also commented that the study focused on access and compared the average distance from a physician dispensing repackaged drugs to a choice of pharmacies accepting workers' compensation prescriptions. It was determined that the average distance from a patient to a pharmacy dispensing drugs in workers' compensation is as little as 0.8 miles, with one choice of pharmacy. Increasing the distance with more choices (1 to 5) of pharmacies, there is an average of 1.2 miles for two pharmacies and 2.2 miles for five pharmacies. Another way to look at this is the distance from a worker's home to the nearest pharmacy that dispenses drugs. This was measured in 2000 with a smaller sample of workers' compensation data, and it was found to be an average of 2 miles. It has been projected that after workers' compensation reform in 2004, access in regard to average distance from a worker's home to a pharmacy taking workers' compensation was about 1.2 miles (with an increase as choice of pharmacies increases). Mr. Neuhauser stated that access has not gotten worse and may have gotten better since SB 288. Access therefore does not seem to pose an issue, stated Mr. Neuhauser, either from the physician's point of view or from the worker's compensation process.

Mr. Neuhauser then stated that compliance has to be better in regard to receiving drugs. Some patients do not receive drugs when the physician recommends them and gives them a prescription, but if they always get the drug from the physician, compliance will always be better. Most compliance problems arise when patients fail to take the appropriate regime of the drug once the drug is obtained. Many of the physician-dispensed drugs have their own, appropriate compliance incentives (for example, pain medication, and gastro-intestinal drugs). Patients might not get these prescriptions filled if they do not have the particular symptoms, and that may not pose a particular problem for their recovery. Mr. Neuhauser stated that the research in this area is pretty much non-existent. A lot of the research is done by pharmacy associations and therefore is not particularly reliable. There has not been a lot of research or literature found demonstrating that physician-dispensing leads to better health outcomes.

Mr. Neuhauser stated that there is very little support for the issue of life-saving and time-critical therapies as raised at regulatory hearings. Looking at the top 50 drugs, none of physician-dispensed drugs suggest life-saving or time-critical issues. However, it is important to consider whether a time-critical situation is created in the majority of physicians' offices where drugs are not dispensed and whether this is a malpractice issue, as well as whether or not MediCal is creating a risky practice for MediCal patients because they do not allow physician-dispensing. Mr. Neuhauser stated that there does not seem to be substantial evidence to support the argument that the practice of not allowing physicians to dispense drugs is life-threatening, so that this concern seems unfounded.

Mr. Neuhauser stated that arguments against physician-dispensing say that it limits patient information and reduces patient safety checks. However, it is difficult to imagine that physicians

are not going to supply information about a drug if they are prescribing the drug but not dispensing it. If physicians are giving information and pharmacists are giving information, then there are potentially two sources of information. Another issue is that when patients go to their customary pharmacy for drugs for all of their medical conditions, the pharmacist is likely to know all of the drugs that a patient is taking and any harmful interactions.

Mr. Neuhauser stated that limited research suggests that dispensing physicians tend to over-prescribe or prescribe more drugs more frequently. Ranitidine (Zantac) is an example of a potential conflict, as it is the number one physician-dispensed drug, making up 15% of drugs dispensed by physicians, while not in the top 50 drugs for pharmacies. This is 30% of all the dollars spent for physician-dispensed drugs, but it is about 1/20th as frequently dispensed in a pharmacy.

Mr. Neuhauser stated that physician-dispensing drugs cost an average of almost six times what the same drugs would cost from a pharmacy. This is an estimated extra $300 million on a paid basis for 2006 and an extra $600 million on an incurred basis for employers' premiums in policy-year 2006. He also stated that there is little or no evidence of improved outcomes or other advantages connected with physician-dispensing, as well as there is no evidence of access problems. Mr. Neuhauser next stated that further research should be done on the impact of physician-dispensing on over-prescribing. He also stated that in the near future, the written report on the study will be circulated in the future for peer review. In addition, a model should be developed to allow all the factors involved with physician-dispensing to be tested for use by policy-makers, stakeholders, and legislators.

Commissioner Salazar asked for clarification of the $700 million mentioned. Mr. Neuhauser replied that this is based on what insurers expect the cost to be for injuries occurring in a policy year. This is usually double what the insurers are currently paying for a calendar year for all cases that happened in the past. Insurance companies would have to price policies for the additional expense for physician-dispensing drugs if they expect physician-dispensing to continue, and responsible employers would be paying additional dollars.

Commissioner Davenport asked for clarification about the frequency prescribing Zantac. Mr. Neuhauser replied that physicians may not be prescribing Zantac for a particular injury, but rather for the side-effects of the other medications prescribed. Commissioner Davenport asked why there would be more frequent practice of prescribing this medication by physicians who dispense than those who do not. Mr. Neuhauser replied that it may be that Zantac is prescribed at the same time as another drug in the event that it is needed.

Commissioner Steinberg asked what the law covers regarding the physician who is dispensing drugs. Mr. Neuhauser replied that SB 228 stated that if a drug was not on the MediCal list, it would be priced under the old worker's compensation fee schedule. Any National Drug Code (NDC) for a drug that is not in the Medi-Cal formulary gets priced under the old fee schedule. Commissioner Steinberg asked how the Commission started this study. Ms. Baker replied that it developed out of the RAND Assembly Bill (AB) 749 medical treatment study. Pursuant to that study, Barbara Wynn from RAND presented a paper on repackaged drugs. The Commission

voted to determine the impact of the cost of repackaged drugs. At that time, Mr. Neuhauser stated, the data about how many physicians were dispensing drugs were not available.

Chair Wei asked if it can be determined how many prescriptions out of the 1.2-1.3 million prescriptions reviewed in the study went to the same patient. Mr. Neuhauser replied that currently that cannot be determined. However, the database could be reconstructed to determine which patients are getting which drugs and what the outcomes are, especially return-to work rates. Chair Wei asked if the size of the prescription can be determined. Mr. Neuhauser replied that it could be and that the average number of pills in repackaged drugs is smaller but generally the size is similar to pharmacy-dispensed drugs. Chair Wei then asked about the timeframe of the next steps of the study. Mr. Neuhauser replied that there would be about six weeks for a draft to be circulated and for there to be peer review.

Steve Cattolica, representing physicians in different organizations, asked if the method used for the 1.2-1.3 million pre-SB 228 claims that were studied could be described. Mr. Neuhauser replied that a distribution of drugs that was used in 2004 was used, and the most recent pricing from MediCal pricing and physician-dispensed drug pricing was used. Mr. Cattolica asked if the impact of utilization review was evaluated. Mr. Neuhauser replied that the dataset may be updated in the future. Mr. Cattolica stated that that would be critical. Chair Wei asked how utilization review would apply in physician-dispensing. She stated that utilization review operates on the payment side not the dispensing side. Mr. Cattolica agreed. Chair Wei stated that the issue is whether or not the physician is paid, and that if the physician is not paid, she would assume that the physician would stop dispensing. Mr. Cattolica stated that that could affect utilization.

John Swan from CompPartners stated that they would supply data if the study wanted to look at how utilization review affects physician-dispensing. Mr. Neuhauser stated that he would try to look into pharmacy-dispensing.

Sandra Wood from Voters Injured at Work stated that she was injured at work and denied medication by the insurance adjuster and that this is a compliance issue. She asked whether there would be rules that insurance adjusters would have to follow. Mr. Neuhauser replied that recently there was a law in the latest workers' compensation reforms that makes initial treatment up to $10,000 immediately approved and that this might help prevent some of the problems with cases like hers. Ms. Wood stated that access to drugs in workers' compensation should include information to insurance adjusters.

Charles Smith, of H.J. Harkins**,** stated that he does not believe that the number of 5,000 dispensing physicians is accurate, that it is much lower than that. He stated that he would expect under 1500 physicians. Mr. Neuhauser stated that they looked at 2000 individual federal identification numbers in the data. Mr. Smith asked if it could be the same provider at different offices. Mr. Neuhauser replied that this could be individual physicians and that there could be more than one location. He also stated that a third of repackaged drugs are handled by an intermediary between physicians and insurance companies. He stated that it would be helpful if the five or six major repackagers in California could provide an estimate. Mr. Neuhauser said

that he would follow up on SCIF's reimbursement policy on certain drugs. Mr. Smith stated that they would like to have access to the study's data.

Michael Leedie, an injured work, stated that he is an injured worker and he would like to know if the Commission is considering sanctions on insurance companies who deny treatment. Chair Wei stated that the Commission is not a policy-setting or rule-making body, but a research organization. Chair Wei stated that Commission staff could talk with Mr. Lee about how to make his issues heard with the Legislature.

Bonnie Kerenyi stated that she is an injured worker and was injured 17 years ago. To this day, she has been carrying her medical expenses and the insurance company has refused to reimburse her. She stated that she cannot afford medication prescribed by a physician. She then asked if injured workers are entitled to get reimbursement for over-the-counter medications. She also asked why pharmaceutical companies are not regulated so that they would not be able to charge such high amounts for medications. Chair Wei stated that the appropriate channel for Ms. Karenyi's first issue is the Legislature, but that Commission staff, especially Judge Taylor, could talk with Ms. Karenyi about her second concern.

CHSWC Vote

Commissioner Wilson moved to approve that CHSWC release for circulation and feedback the annotated slides and the draft paper when available on the Repackaged Drug Study, and Commissioner Thacker seconded. The motion passed unanimously.

Barriers to Occupational Health Services for Low-Wage Workers in California

Nanette Lashuay, MA, Assistant Clinical Professor, University of California, San Francisco, School of Nursing, Department of Community Health Services

Nanette Lashuay stated that the study's co-author, Dr. Robert Harrison, was not able to attend the meeting. She stated that she wanted to thank the many community-based organizations that helped in this study and that it is very difficult to talk to people in underground operations and jobs because those people do not feel comfortable talking about low-wage working conditions. The report focuses on identifying barriers for low-wage workers to occupational health services for injuries and illnesses. Ms. Lashuay stated that low-wage workers make under $10/hour. In other studies, the range can go from minimum wage to $20. The study uses the average living wage as the cut-off. According to the Employment Development Department, there are about 3.7 million workers in these occupations. Of this number, about 20% of the workforce, or about 2 million, are unreported workers, working in jobs where companies do not report their employees, such as those working in factories or as janitors, gardeners, farm laborers, food-service workers, landscape-maintenance workers, and manual laborers. The majority are non-white and immigrant workers.

Ms. Lashuay stated that the study focuses on the problems these workers are facing in obtaining and filing for workers' compensation and accessing appropriate medical care. The study also looks at prevention efforts by industries and the critical role that prevention could play in reducing workers' compensation expenditures and worker pain and disability. The study methodology involved interviewing 149 workers around Los Angeles and the San Francisco Bay Area with diverse ethnicities (from Latin America, Asia, the Middle East, and Africa) and diverse occupations. The study also focuses on the building maintenance industry to look at prevention measures because a lot of underground companies are competing with some of the larger companies, therefore making it a very competitive industry to work in. Another aspect of the study was the health care available for low-wage workers and to what extent industries provide healthcare for their workers.

Ms. Lashuay stated that it was easy to determine what the problems are but difficult to determine how prevalent the problems are. Half of the problems identified in this report were common responses across the different locations covered by the study. She stated that the report also focuses on the reasons for companies not being in compliance with legal requirements, with one of the key reasons being that the competition from the large underground community in California causes other businesses to violate the law. Another factor is the criminal underground economy, with about 10,000 trafficked workers in California that are held in conditions close to slavery, as well as workers who are considered to be in indentured servitude.

Ms. Lashuay stated that during the course of the study, SB 298 was passed. To some extent, the provisions of this bill probably would not have too much of an effect on the population of this study, as many low-wage workers are not getting into the system at all. Ms. Lashuay stated that key factors affecting whether people are going to run into barriers or not include:

- Employment in the underground economy. The underground economy produces $160 billion per year in goods and services, with about 2 million workers employed by businesses that do not pay taxes, probably do not have workers' compensation insurance, and do not follow laws.
- Working in a small business. Some of these requirements for operating a business are complex, and many small businesses, as well as many new businesses which are small businesses, are often owned by immigrant or non-English speakers who do not understand legal compliance issues.
- Limited English and limited literacy. The INS estimates that there are 3 million undocumented residents in California right now, or 50% of blue collar workers, and it is likely that most of them have limited English as well as limited literacy. For these workers, looking at outreach materials and insurance forms would be difficult.
- Lack of benefits. About 40-50% immigrants or undocumented workers do not have health insurance in California, and about 76% nationally do not have sick leave.
- Lack of union representation. Differences were highly dramatic regarding health and safety issues especially in agriculture and building maintenance (janitors), which were both unionized and non-unionized. Conditions were much better for union workers, those most likely working for larger companies, than for non-unionized workers.

Ms. Lashuay stated that additional barriers involved fear of retaliation, which was the most common problem.
Ms. Lashuay stated that the report includes recommendations, including: increase inspection in target industries; involve community-based organizations; involve local government; encourage more effective outreach campaigns; and strengthen the community-health system.

Cindy Gottlieb, a nurse practitioner in a community center in Los Angeles working with the garment industry, stated that OSHA inspections that were done recently were unsettling to workers and have not resulted in increased compliance, at least not in Los Angeles. She stated that workers need safe places to report to during an inspection at their workplace. This indicates that there needs to be protections when inspections occur. She also stated that Ms. Lashuay's recommendation to help workers fill out claims needs to be supported by a way to inform workers and the public about which insurance carriers are used by small businesses. Commissioner Davenport asked if this OSHA experience occurred in California, and Ms. Gottlieb replied that it was in North Carolina. Chair Wei stated that currently, there is an effort to increase the number of Cal/OSHA inspectors. She also stated that there is legislation pending that would create a database to provide information on insurance companies by business. Ms. Baker stated that the report would be made publicly available for comment.

CHSWC Vote

Commissioner Wilson moved that the draft paper on "Barriers to Occupational Health Services for Low-Wage Workers in California," be released for circulation and feedback, and Commissioner Thacker seconded. The motion passed unanimously.

CHSWC Study of Health Care Organizations

Lach Taylor, Workers' Compensation Judge, CHSWC
Christine Baker, CHSWC Executive Officer
Chris Bailey, Research Analyst, CHSWC

Judge Taylor stated that Assembly Member Rick Keene requested that Commission staff examine the effectiveness and viability of Health Care Organizations (HCOs) in today's market and compare this model for medical care delivery with Medical Provider Networks (MPNs) and with the employee-choice model for provision of medical treatment in workers' compensation. HCOs were organized to bring managed care into workers' compensation in 1993. Judge Taylor stated that the viability of HCOs appears to be marginal now because there are other options for employers. However, he stated that, as designed, HCOs look like they might be able to bring the best of managed care into workers' compensation. Also, as designed, they would have methods for internal review and quality of care and ways to ensure that medical decisions are made by qualified medical providers. They would also have an internal grievance process and integration of disability management.

Judge Taylor stated that at this time, data available on HCOs is through self-reporting by HCOs. He stated that the data reported by some HCOs suggest that HCOs can fulfill the potential to reduce costs and reduce time lost fom work. Sufficient data have not been systematically collected by the State to definitively evaluate the costs and benefits of HCOs. The market viability of HCOs is jeopardized by the introduction of Medical Provider Networks (MPNs) that allow employers longer control over medical costs through Preferred Provider Organization (PPO) containment without the regulatory fees that are currently imposed on HCOs. HCOs should be made more competitive and compatible with MPNs so that both options remain open to employers until research and experience can demonstrate the preferred system for providing medical treatment.

CHSWC Vote

Commissioner Wilson moved that the CHSWC Report on Health Care Organizations requested by Assembly Member Rick Keene be released, and Commissioner Davenport seconded. The motion passed unanimously.

Chair Wei thanked all the organizations that gave access to their data to the Commission for this study.

Executive Officer Report

Christine Baker, CHSWC Executive Officer

Ms. Baker stated that Commission staff has been extremely active preparing for the April 7th disaster preparedness forum. The purpose of the forum is to bring together both public and private partnerships to improve catastrophe preparedness. The Agenda is packed and there has been response from over 200 attendees. The staff is grateful to the contributions of Cal/OSHA, SEIU, SwissRe, RMS, and RAND. Ms. Baker stated that she believes this forum is a true public service.

Ms. Baker stated that Commission staff has also been involved in several briefings to the Legislature on studies that CHSWC has conducted. In addition, CHSWC has been invited by the employer community to provide a brief on projects that CHSWC is conducting. Ms. Baker also stated that Commission staff has recently received a number of bi-partisan requests from the Legislature for issue papers and suggested language. These include: a request from Assembly Member Rick Keene on the study of the viability of HCOs; a request from Assembly Member Nava for technical assistance on AB 1987; a request from Assembly Member Abel Maldonado regarding Self-Insurance Groups and their Contributions on Reserves and Taxation and the need for a tax exemption; and a request from Assembly Member Delatorre regarding proof of coverage. These requests are bi-partisan and meet the needs of both of employers and labor.

Ms. Baker stated that the following technical reports are ready for Commission's decision. The first report is an updated and revised recommendation to the AD on Medical Treatment Guidelines. This is a very minor change. Labor Code 77.5 requires the CHSWC to conduct a

survey and evaluation of evidence-based, peer-reviewed, nationally recognized standards of care, including existing medical treatment utilization standards, and including independent medical review, as used in other states, at the national level and in other medical benefit systems. It also specified that the survey should be updated periodically.

Ms. Baker stated that the Commission contracted with RAND and put out a report which found that ACOEM was the best available guideline for the short term and that the American Academy of Orthopedic Surgeons (AAOS) appeared to be the only other guideline that met the evaluation criteria and could supplement the ACOEM guidelines for certain procedures. Since then, AAOS has been withdrawn as a guideline and is not publicly available. Commission staff therefore recommends that the Commission's recommendations to the AD be updated. The update would eliminate the AAOS as a viable guideline at this time. This is not a major policy change. This is clean up action that reflects the changes currently regarding AAOS.

The second study, which is part of the RAND study, also suggested that the demonstration project that Dr. Nuckols Scott is proposing and in which the feasibility study has been done, is a longer-term strategy. Commission staff has also heard from many members of the workers' compensation community that CHSWC should, on an advisory basis, identify protocols that could supplement the ACOEM guidelines. CHSWC could start off systematically and keep adding as guidelines are identified that meet a specified evidence-based criteria for workers' compensation and make that available as a cadre of protocols that supplement the ACOEM guidelines. Judge Taylor stated that a number of insurance carriers do this and that more than a single set of guidelines is used by physicians in medical decision-making. Ms. Baker stated that Commission staff believes this is part of its mandate, but would like Commission approval to proceed. She stated that at this time, Commission staff would like to suggest to the Commission that the report conducted in November 2005 be revised and that a project be initiated that would be an updated survey and would post the guidelines.

Ms. Baker next stated that under the auspices of the University of California Berkeley and Juliann Sum, the Commission voted to develop information materials for carve-outs along with updated information from the reforms. This material has been developed working with carve-out experts from both the union and the employer side. Commission staff has circulated the informational sheets to advisory groups and has received some feedback. Minor technical changes are being made. Ms. Baker asked if the Commission would like the report finalized and made available as soon as all feedback is incorporated.

Judge Taylor stated that Assembly Member Nava asked for technical advice on a bill that would modify the way the Supplemental Job Displacement Benefit (SJDB) was paid to workers who were not offered return to work. The problems with the current eligibility for this benefit were examined with the assistance of Juliann Sum. This is a difficult benefit to administer, so that the Commission has attempted to develop a single set of factors that could apply to job offers for return to work to evaluate eligibility. Currently, eligibility for SJDB is determined long before the amount that is payable is known. The bill would make the benefit determination coincide with the determination on permanent disability at a flat rate that is not dependent upon the rating and that flat rate should be in the mid-range of the benefit. Commissioner Steinberg asked

whether the recommendation is being made by CHSWC or whether it is being incorporated in the bill. Ms. Baker stated that the paper includes both a quick correction to the language in the bill as well as a suggested alternative from the Commission. Commissioner Steinberg asked if the correction would be to establish a fixed amount rather than a floating number for the SJDB. Judge Taylor replied that it would be. There is no recommendation in the CHSWC paper to exempt the SJDB from being settled.

Judge Taylor stated that another request from Senator Abel Maldonado asked to examine the tax effects of Self-Insured Groups (SIGs). Group self-insurance became an authorized alternative to buying insurance in 1993. There are now more than 20 self-insured groups operating in California. There has been an unexpected tax consequence that was not expected. The self-insurance group is a private non-profit organization. However, Judge Taylor stated, non-profit does not mean non-taxable, and non-profit organizations are not tax-exempt. Employers pay into a fund to cover future liabilities for the life of claims that may come up this year, and almost 9% is subject to state tax. In contrast, insurance companies are taxed at 2.35%, and self-insureds may set aside reserves or may "pay as they go." Judge Taylor stated that there are some possible solutions that appear to be worth considering, including tax-exemption, or changing the way the taxable income is calculated to make it the same as the way federal tax law applies to insurance companies.

Commissioner Davenport asked what relationship this issue has to workers' compensation. Judge Taylor replied that taxation has an effect on the ability of employers to pay workers' compensation. Commissioner Wilson stated that the report is excellent, and Judge Taylor stated that the role of the Commission is to point out what the effect of taxation is on labor and management in the workers' compensation system.

Ms. Baker stated that two months ago, the Commission completed a background paper on the impact of terrorism that has been circulated to the public. There has been no feedback and the report is ready for posting.

CHSWC Vote

Commissioner Davenport moved to adopt all six of the Executive Officer and staff recommendation, which include the following, Revised CHSWC Recommendations to the AD on the Medical Treatment Guidelines, systematic identification of guidelines that meet a specified evidence-based criteria for workers' compensation, CHSWC Study of AB 1087 and Return to Work Incentives and Alternatives, CHSWC Background Paper on the Impact of Terrorism on California Workers' Compensation, and CHSWC Issue Paper on the Tax Status of Self-Insured Groups (SIGs), as well as to finalize the carve-out informational booklet "How to Create a Workers' Compensation Carve-out in California: A Booklet for Unions and Employers" and make it available for the parties interested in carve-outs. Commissioner Salazar seconded. The motion passed unanimously.

Adjournment

As there was no public comment at this time, the meeting was adjourned at 3:50 p.m. The next CHSWC meeting is scheduled for Thursday, July 6th, in Oakland.

Approved:

Angie Wei, Chair Date

Respectfully submitted:

Christine Baker, Executive Officer Date